



<p><b>Provide the listed documents with this referral to enable assessment of your patient's eligibility for complex care coordination program.</b>  <b>Without the documentation your patient will be ineligible.</b> (Please supply – other relevant supporting documentation such as referrals or reports to/from Sleep Study / Psychiatrist / Psychologist / Podiatrist / OT etc.)</p>		<input type="checkbox"/> GPCCM Plan <input type="checkbox"/> MHCP only - for mental health diagnosis. (Please note if ineligible for GPCCM PLAN a Mental Health Care Plan must be provided) <b>(MUST also have a current 715 Health Assessment completed &amp; attached)</b>	
<p><b>The patient identifies as:</b></p>		<input type="checkbox"/> Aboriginal and/or Torres Strait Islander	
<p><b>The eligible chronic disease type/s which require high complexity and care coordination support:</b></p>		<input type="checkbox"/> Diabetes <input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Respiratory/COPD/Asthma <input type="checkbox"/> Mental Health Condition <input type="checkbox"/> Cancer - Type if known:	
<p><b>Referral Date:</b></p>	<p>Preferred Practice Contact: <input type="checkbox"/> GP <input type="checkbox"/> Practice Nurse</p>		
<b>REFERRING GP DETAILS</b>			
<p><b>Name:</b></p>			<p><b>Phone No:</b></p>
<p><b>Practice Name:</b></p>	<p><b>Address:</b></p>		
<p><b>Signature:</b></p>			<p><b>Date:</b></p>
<p><b>Reason for Referral:</b></p>			
<b>PATIENT DETAILS</b>			
<p><b>First Name:</b></p>			<p><b>Surname:</b></p>
<p><b>DOB:</b></p>	<p><b>Gender:</b></p>	<p><b>Phone No:</b></p>	
<p><b>Residential Address:</b></p>			<p><b>Post Code:</b></p>
<p><b>Medicare No:</b></p>	<p><b>Ref No:</b></p>	<p><b>Expiry Date:</b></p>	
<p><b>Other contact details if applicable:</b></p>			

Please email completed form to [itc@ungooroo.com.au](mailto:itc@ungooroo.com.au)